DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #04-03

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2005

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 438

7. FEDERAL BUDGET IMPACT:
a. FFY 2005 $ 248,000
b. FFY 2006 $ 1,982,015

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F
Pages 1 thru 18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F
Pages 1 thru 18

10. SUBJECT OF AMENDMENT:
Care Management

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:
Gary J. Daniels is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Daniels

14. TITLE:
Acting Secretary

15. DATE SUBMITTED:
December 27, 2004

16. RETURN TO:
Gary J. Daniels, Acting Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-2210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 28, 2004

18. DATE APPROVED:
February 17, 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2005

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
James G. Scott

22. TITLE:
Acting Associate Regional Administrator for Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER, TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Kansas**

Kansas Medical Assistance Program (KMAP),
MCO, PCCM and enhanced PCCM programs

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Kansas Kansas Medical Assistance Program (KMAP). All Medicaid beneficiaries as described in Section C are required to enroll in either a managed care organization (MCO), or a primary care case management (PCCM) program. The enhanced PCCM program is an enhanced primary care case management program in which Kansas PCCM Primary Care Physicians (PCPs) have an administrative entity assisting with case management. The administrative entity has developed care management and disease management strategies targeted to their respective populations. The PCPs receive the standard management fee and all providers are paid on a fee-for-service basis. The administrative entity receives an additional administrative management fee for the enhanced services. Section E target groups are not subject to mandatory enrollment but can voluntarily enroll.

2. The objectives of these programs are to reduce costs, reduce inappropriate utilization, and ensure adequate access to care for Medicaid recipients.

3. This MCO program is intended to enroll Medicaid recipients in MCOs, which will provide or authorize all primary care services and all necessary specialty services, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. The MCO/PCCM assigned practitioner will act as the PCP. The PCP and enhanced PCCM are responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under these programs.

4. The PCP and enhanced PCCM will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PCP and enhanced PCCM will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of recipients enrolled in the program. In the PCCM program, the PCP will receive a per member per month payment for case management services.

5. The enhanced PCCM entity will receive a per enrollee per month payment for enhanced case management services.

6. Recipients enrolled under this program will be restricted to receive covered services from the PCP or upon referral and authorization of the PCP or MCO. The PCP will manage the recipient's health care delivery. The KMAP program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM and enhanced PCCM programs. Recipients will have a minimum of 15 days to make the selection but may change the initial selection at any time. Enhanced PCCM exists in counties where the State has an administrative contract with an entity providing care management PCCM PCPs with care management. All individuals covered under this option who reside in these counties will be able to choose from among multiple Kansas PCCM PCPs.

7. Non-MCO contractors will act as enrollment brokers in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

8. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO. Co-payments will apply for those services provided under the PCCM program.

9. The state requires recipients in PCCM and enhanced PCCM to obtain services only from their assigned PCP or through referral to a Medicaid-participating provider who provides such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

10. PCCM may operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in a PCCM. The MCO and PCCM programs may operate in the same counties where MCOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM program. Recipients will have the option to select from a PCCM PCP and MCO where available. The Medicaid recipient must choose one of these options for the delivery of health care services.

11. Public Process for proposed changes in the Kansas Medical Assistance Program (KMAP) MCO and PCCM and enhanced PCCM programs. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act for proposed changes in KMAP programs. Public notice will be published in the Kansas Register which is available to the public on a weekly basis.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. The KMAP program is available in selected counties in Kansas. Mandatory enrollment provisions will not be implemented unless a choice of at least two PCCM PCPs or a combination of MCO and the PCCM and enhanced PCCM program is available.

3. Kansas has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

4. Kansas will monitor and oversee the operation of the mandatory/voluntary managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

5. Kansas will evaluate compliance by review and analysis of reports prepared and sent to the Kansas Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Kansas Medicaid agency.

6. Reports from the grievance and appeal process will be analyzed and used for evaluation purposes.

7. Kansas staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.

8. Kansas staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

C. Target Groups of Recipients for Mandatory Enrollment

The KMAP program is limited to the following target groups of recipients:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

2. Aged, Blind and Disabled Adults (SSI).

D. Mandatory Enrollment Exclusions

1. The following groups will not be mandatorily enrolled in managed care:

   a. Clients with Medicare coverage

   b. Clients residing in nursing facilities and receiving custodial care

   c. Clients residing in intermediate care facilities for the mentally retarded (ICF/MR)

   d. Clients who are residing out of state (ie. Children placed with relatives out of state, and who are designated as such by HHSS personnel);

   e. Certain children with disabilities who are receiving in-home services, also known as the Katie Beckett program

   f. Aliens who are eligible for Medicaid for an emergency condition only

   g. Clients participating in the refugee resettlement program.

h. Clients receiving services through the following home and community based waivers:

1. Persons with mental retardation or developmental disabilities

2. Individuals from ages 16-64 with physical disabilities

3. Technology assisted children

4. Individuals with traumatic brain injury

5. Frail and elderly individuals

6. Children with severe and emotional disturbance

i. Clients who have excess income (i.e. spenddown - met or unmet)

j. Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state

k. Clients having other insurance

l. Clients enrolled in another Medicaid Managed Care Program

m. Clients who have an eligibility program that is only retro-active.

n. Clients under the custody of the Juvenile Justice Authority

o. Clients residing in a State institution

p. Clients designated as participants in the administrative lock in program.

q. Indians who are members of Federally recognized tribes when the MCO or PCCM and enhanced PCCM is:

(i) The Indian Health Service; or
(ii) An Indian Health Program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with Indian Health Service.

r. Children under 19 years of age who are:

(i) Eligible for SSI under Title XVI; or
(ii) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

E. Target Groups of Recipients for Voluntary Enrollment

The state must provide assurances that, in implementing the state plan managed care option, it will not require the following groups to enroll in an MCO or PCCM and enhanced PCCM:

1. Indians who are members of Federally recognized tribes, except when the MCO or PCCM and enhanced PCCM is:

a. The Indian Health Service; or
b. An Indian Health Program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

2. Children under 19 years of age who are:

   a. Eligible for SSI under Title XVI; or
   b. Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

F. Enrollment and Disenrollment

1. All recipients will be given the opportunity to choose from at least two KMAP providers. This will be multiple PCCM providers or a combination of PCCM providers and an MCO option or a choice of MCOs if two or more are available in a county. If a recipient has a prior provider relationship they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

   Kansas contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

   a. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees. (EQRO performs this function).

   b. Answer KMAP-related questions from recipients and providers.

   c. Prepare enrollment materials for KMAP program, for Department approval, and store KMAP materials (MCO, PCCM and KMAP in general).

   d. Process new enrollments and transfers for those KMAP eligibles identified by the Department.

   e. Process the recipient's choice and assign to the provider. (PCCM and enhanced PCCM only receives a monthly card).

   f. Log grievances and requests for special authorization from KMAP enrollees.

   g. Perform various quality assurance activities for the KMAP program. This is inclusive of the QAT process.

   h. Supply an enrollment packet to the recipients that includes MCO andPCCM materials and information supplied by the state and plans.

   i. Enrollees who select the PCCM option are then eligible for enhanced PCCM where available. The state will utilize a software package to identify high risk enrollees. The identified enrollees will be listed on a roster and provided to the enhanced PCCM contractor. The enhanced PCCM contractor will invite the enrollees to participate in the enchanced PCCM program. Enhanced PCCM information will be provided by the ASO after approval by the state and selected by the enrollee.

   j. Provides enrollment counseling which includes:

      1. Inquiring about patient/provider experience and preference.

      2. Providing information on which MCOs or PCCM PCPs are available to maintain a prior patient-provider relationship.

3. Facilitating direct contact with individual PCPs, PCCM and enhanced PCCMs and MCOs, as necessary.

4. Providing any information and education concerning the enrollment process, individuals', benefits offered, the enrollment packet, client rights' and responsibilities and any of the other information provided for in this section.

2. If the mandatory recipient fails to choose an MCO or PCCM PCP within a minimum of 15 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCP in a PCCM or to a MCO. Kansas enrollment system can identify the voluntary recipients from data available to the system and will insure that these populations are not autoassigned. If a voluntary recipient does not choose to enroll with the PCCM or MCO, they will receive services on a fee-for-service basis.

3. Mandatory default enrollment will be based upon maintaining prior provider-patient relationships, proximity and prior familial/provider relationships or, where this is not possible, on maintaining an equitable distribution among managed care entities.

4. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

5. Any selection or assignment of an PCP, MCO or PCCM and enhanced PCCM may be changed at any time.

6. PCPs, MCOs and PCCM and enhanced PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

7. The MCO and PCCM and enhanced PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

8. An enrollee who is terminated from an MCO or PCCM and enhanced PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or PCCM and enhanced PCCM upon regaining eligibility to the extent possible.

9. The recipient will be informed at the time of enrollment of the right to disenroll.

10. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the MCO.

11. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

12. A general explanation of terms regarding enrollment and disenrollments (lock-in and referrals).

13. A description of the delivery system.

14. The responsibilities of the providers.

15. Enrollment procedures.

16. Provide information on services outside the MCO contract including the access to emergency services.

G. Process for Enrollment in an MCO/PCCM and enhanced PCCM

The following process is in effect for recipient enrollment in the KMAP Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among Managed Care Entities (MCEs) regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (6th grade reading level or less). Materials will be translated into Spanish and other languages upon request, including Braille.

3. Recipients will be able to select an MCO or PCCM from a list of available managed care entities in their service area. If the recipient wishes to remain with a PCP or plan with whom a patient/physician relationship is already established, the recipient is allowed to do so to the extent possible. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection for the mandatory poplulation is not made within the 15 day period describe above, the Medicaid program shall assign a MCO or PCCM and enhanced PCCM in accordance with the procedures outlined in F above.

4. The MCO and PCCM and enhanced PCCM will be informed electronically or in writing of the recipient's enrollment in that plan.

5. The recipient will be notified of enrollment and issued an identification card.

6. Additionally, each MCO will provide recipients the following information as soon as practical after activation of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

c. Names and locations of current network providers, including providers that are not accepting new patients.

d. Any restrictions on freedom of choice.

e. The extent to which there are any restrictions concerning out-of-network providers.

f. Policies for specialty care and services not furnished by the primary care providers.

g. Grievance and appeal process.

h. Member rights and responsibilities.

H. Maximum Payments

The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with generally accepted actuarial principles and practices as required by 42 CFR 438.6(c). State payments to contractors will comply with actuarial soundness in 42 CFR 438.6(c).

I. Covered Services

1. Services not covered by the KMAP program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the KMAP Program and the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with MCOs and PCCM and enhanced PCCMs and is specific to the service type and service provider.

2. MCOs are encouraged to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics and Indian Health Clinics.

3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the KMAP Program. "Emergency services" are defined in the MCO contract.

4. The PCCM shall be responsible for managing the services marked below in column (7). The MCO capitated contract will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by Medicaid fee-for-service (without referral).

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Not Required or Non-Waiver Services (7)
Service Category ~~Capitated Svcs~~ or PCCM referrals req. a referral:					
Inpt. Hospital	X	X			X
Non-psych	X	X			
Profess./clinic & other lab/x-ray	X	X			
Outpat. Hosp-lab & x-ray	X	X			
Outpt. Hosp - All other	X	X			
Maternity/Delivery Services	X	X			X if beneficiary PCCM is OB
Pharmacy/ Prescription Drugs	X	X			
Home Care & Hospice Services	X	X			X
Transportation - Ambulance & Emergency	X	X			X
Transportation - Other Medical and non-emergency	X	X			X